



Q. PHYSICIANS AND PRIMARY CARE PROVIDERS

Description. Physicians and other primary care providers (PCPs) must adhere to the PA requirements identified in this policy manual ([Chapter 300](#), [Chapter 400](#) and [Chapter 800](#)).

Refer to [Chapter 300](#), Policy 310 for complete information regarding covered PCP and physician services.

Fee-for-service surgeons, or the hospital employing the surgeon, must obtain a separate and distinct AHCCCS PA number from that of the hospital prior to providing the transplantation and elective/non-emergency surgeries (except voluntary sterilization). (Refer to Hospital Inpatient Service Authorization.) The AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, responds to all transplant requests. Assistant surgeons essential to the service and anesthesiologists do not require a PA number.

Procedures. PA requests may be submitted via mail, fax or telephone prior to providing service.

R. PODIATRY SERVICES

Description. Routine foot care will only be covered for members with a systemic disease requiring the care of a physician. In addition, the disease must be of sufficient severity that performance of such procedure by a nonprofessional person would be hazardous. Routine foot care includes the cutting or removal of corns or calluses; the trimming of nails (including mycotic nails) and other hygienic and preventive maintenance care typically within the realm of self-care.

Refer to [Chapter 300](#), Policy 310, for complete information regarding covered podiatry services.

All podiatry services not covered by Medicare require PA.

Coverage for approved routine foot care must not exceed two visits per quarter or eight visits per contract year. Coverage for mycotic nail treatments will not exceed one bilateral mycotic nail treatment (up to 10 nails) per 60 days. This coverage limitation does not apply to members who are under the age of 21 in both the Medicaid (EPSDT program) and the KidsCare programs.

Procedures. PA requests for podiatry services may be submitted via mail, fax or telephone.



S. PRESCRIPTION DRUG/PHARMACY SERVICES

Description. FFS pharmacy services that exceed \$500.00 per prescription require PA. All FFS pharmacy PA is conducted through the AHCCCS pharmacy Contractor.

All pharmacy claims are subject to post-payment review pursuant to Arizona Revised Statutes §36-2903.01.

Refer to [Chapter 300](#), Policy 310, for complete information regarding covered prescription drug/pharmacy services.

T. REHABILITATION THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)

Description. Facilities and independent rehabilitative therapists (occupational, physical and speech therapists not employed by the in-patient hospital or nursing facility providing the service) must obtain separate and distinct prior authorization (PA) numbers for rehabilitation therapies.

AHCCCS covers therapy services if the following conditions are met (these conditions do not apply to members who are under the age of 21 in both the Medicaid [EPSDT program] and KidsCare programs):

1. The member's medical condition for which services are prescribed is acute
2. In the case of speech therapy, the member had functional communicative skills prior to the acute event, and
3. There is reasonable expectation of improvement/response to plan of therapy, and there must be documented progress.

AHCCCS covers outpatient speech or occupational therapy only for members who are under the age of 21 in both the Medicaid (EPSDT program) and KidsCare programs, and ALTCS-enrolled members of any age. For other members, refer to [Chapter 300](#), Policy 310.

Refer to [Chapter 300](#), Policy 310 for complete information regarding covered rehabilitation services and [Chapter 1200](#) for complete information regarding rehabilitation services for ALTCS.



Procedures. In addition to information required for all PAs (specified in Policy 810 of this Chapter) the following written documentation must be received by the AHCCCS/DFSM/PA Unit prior to the issuance of a PA number:

1. Nature, date, extent of injury/illness and initial therapy evaluation
2. Treatment plan, including specific services/modalities of each therapy, and
3. Expected duration and outcome of each therapy provided.

Upon concurrent review and/or receipt of above documentation, which substantiates AHCCCS rehabilitation requirements, authorization will be given.

Progress notes must be submitted to the AHCCCS/DFSM/PA Unit every 10 days, as evidence of patient progress for continued authorization (when there is no concurrent review).

U. TOTAL PARENTERAL NUTRITION

Description. Total parenteral nutrition (TPN) is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition.

Amount, Duration and Scope. AHCCCS covers TPN for members 21 years of age and older when it is the only method to maintain adequate weight and strength and for members who are under the age of 21 in both the Medicaid (EPSDT program) and KidsCare programs when TPN is determined medically necessary. The provision of TPN does not have to meet the criterion of being the sole source of nutrition for EPSDT and KidsCare members.

1. Inpatient TPN services do not require PA as long as hospitalization PA procedures have been followed.
2. Facilities and agencies furnishing outpatient TPN services must obtain PA at least one business day prior to initiation of service. Telephone requests are given provisional PA.



3. TPN provided on an inpatient or outpatient basis is not a covered service if the patient:
 - a. Has the ability to absorb enteral feedings, or
 - b. Has a condition where TPN cannot be expected to return the patient to a functional level of health.
4. Medical review of TPN services may be referred to an outside review agency for determination of medical necessity and compliance with these policies.
5. AHCCCS follows Medicare guidelines regarding the provision of TPN services.

Refer to [Chapter 300](#), Policy 310 for complete information regarding covered TPN services.

Procedures. Written medical documentation substantiating compliance with criteria must be received by the AHCCCS/DFSM/PA Unit within five business days of initial authorization request. Medical documentation must include:

1. History and physical which describes member's condition and diagnosis
2. Physician's orders
3. Dietary assessment, including member's weight
4. Any pertinent progress notes (nursing/physician), which currently reflect the member's dietary, eating and functional status
5. Physician progress notes indicating expected outcome of treatment, and
6. Nursing facility records documenting percentage of each meal's consumption by member.

AHCCCS/DFSM/PA, upon receipt of documentation, will:

1. Approve, if in compliance with nutritional therapy criteria.
2. Review with the AHCCCS Chief Medical Officer, or designee, for determination of coverage, if not in compliance with standard criteria.



3. Return the referral form to provider with findings of:
 - a. Approval, date, and note of any limitations; or
 - b. Denial of coverage reason.

V. TRANSPLANTATION (ORGAN AND TISSUE)

Description. Providers must obtain PA from the AHCCCS Transplant Coordinator for all organ and tissue transplantation services to be provided to FFS members. Pursuant to §1903(v) of the Social Security Act and 9 A.A.C. 22, Article 2, FESP members are not eligible for transplantation services.

Refer to [Chapter 300](#) (Policy 310 and Attachment A) in this Manual for complete information regarding covered transplantation services.

AHCCCS also requires providers to obtain PA for transplant related services provided to AHCCCS members who have undergone transplantations not covered by AHCCCS.

AHCCCS utilization management requirements, including PA, are identified below.

Procedures. FFS provider responsibilities regarding medically necessary organ and tissue transplantation services for eligible members include, but are not limited to:

1. The member's transplantation specialist (hematologist/oncologist, cardiologist, gastroenterologist, nephrologist, etc.) must submit a written request to the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, for approval of the transplantation.
2. The following documentation must accompany the written request:
 - a. Current history and physical, including information regarding previous therapy for the disease requiring covered organ and tissue transplantations
 - b. Records of diagnostic studies documenting the diagnosis, member's current medical status and plan of treatment leading to the recommendation of transplantation
 - c. Summary of anticipated outcome for the member.



3. The AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, will verify the member's eligibility. If approval is requested at the end of a month, eligibility will be verified for the following month.
4. The AHCCCS Chief Medical Officer, or designee, will review the submitted documentation, consult with appropriate specialists when necessary, and inform the member's transplantation specialist whether or not transplantation is approved. Written approval will include the following information:
 - a. Designation of the appropriate transplant centers with which AHCCCS maintains a contract, and
 - b. Instructions for obtaining PA for each transplantation service component.
5. AHCCCS will monitor convalescence via progress reports submitted to the Transplant Coordinator, DHCM, Medical Management Unit.
6. Providers must submit claims in accordance with AHCCCS policies and procedures.

Refer to the AHCCCS FFS Provider Manual for additional information. This manual is available on the AHCCCS Web site.

In addition to the PA requirements, providers:

1. Submit to the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, utilization abstracts that include new treatments, medical progress and/or complications, and laboratory results. Weekly submissions begin with the member's approval for transplantation and end with discharge from convalescent care.
2. Offer recommendations for the ongoing treatment and monitoring of the member after discharge.
3. Cooperate with requests from the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, to supply summary data for outcomes studies.

PA requests for transplant-related services provided to AHCCCS members who have undergone transplantations not covered by AHCCCS may be submitted via mail, fax or telephone.